CHAPTER 14

MISCELLANEOUS

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Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE)

Preventative/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) is a service that is funded by the Medicaid State Plan. It was designed to address medically compromising risk factors, which interfere with a patient's ability to maintain an optimal state of health. P/RSPCE support primary medical care. The services are directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability.

It's goals are:

- To link patients with a primary care (medical) home
- To support appropriate use of the health care system
- To reinforce compliance with primary medical care
- To enhance the patient's optimal state of health
- To assist the patient to attain the highest possible level of independent functioning relative to his/her health

This service is available to waiver recipients when medically necessary and when it is:

- Needed to improve his/her response to treatment
- Needed for medication management, compliance with medication regime or assistance with procuring medications
- Needed to assure understanding of how multiple medical treatments relate with effectiveness of the plan to maximize the level of independent functioning.

The attached "Principles for Interaction" must be followed for waiver recipients receiving P/RSPCE.

Effective July 1, 2005, the South Carolina Department of Health and Human Services (DHHS) implement revised policies for the provision of P/RSPCE. Revisions to the policies are as follows:

- **Standing Order**

  The Standing Order (presently in place for public providers) will be limited to six (6) months. A provider must assist the Medicaid beneficiary with locating a Primary Care Physician (PCP) within six (6) months. If a PCP has not been established at the end of that six months, the services will no longer be billable.

- **Communication with Primary Care Physician (PCP)**

  It is essential that the medical home (PCP) approve of the P/RSPCE plan of care. The PCP must approve the plan of care for each individual either verbally or in writing within 30 calendar days. All records must contain documentation for approval of the plan of care from the PCP for service provision to be Medicaid billable. P/RSPCE providers must maintain and document communication with the PCP throughout all

phases of the patient's care.

- **Service Limitation**

  Providers are authorized to bill for a maximum of eight (8) 15 minute units for the Assessment and Plan of Care development and then a maximum of sixty-four (64) units per contract year for service delivery (i.e., Patient Education and Health and Behavior Intervention) per beneficiary. In the event of extreme and unusual circumstances, additional units can be requested by a PCP and may be authorized by the DHHS Review Committee. Only direct, one-on-one contact with the beneficiary, parent, and/or caregiver (e.g., infants or mentally impaired) will be billable. Use of P/RSPCE for the monitoring of a patient's healthcare appointments should be kept to a minimum; only beneficiaries with acute health issues should be monitored. Patients who have demonstrated overall compliance with healthcare instruction should require a minimum of contact or be discharged from services. All beneficiaries should be encouraged and urged toward self-management.

- **Medical Necessity Criteria**

  "Medical Necessity" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. Therefore, only issues that address the medical need(s) of the beneficiary whose Medicaid number is being billed will be reimbursable. Developmental, environmental, and psychosocial risks are billable only when these risks **directly** relate to the medical need as identified by the attending physician.

  Making and coordinating referrals to community resources such as a clothing bank, the housing authority, legal aid, and/or utility companies are not considered medical in nature.

- **Service Documentation**

  P/RSPCE providers are allowed to use check box forms for documentation; however, there must also be a service note summarizing the following:

  - specific risks from the plan of care that were addressed during the session;
  - the response of the beneficiary pertaining to each specific risk; and
  - additional risk(s) that were not resolved and the expected additional services that
  - are medically necessary.

Principles for Interaction Between

Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) and Medicaid Home and Community-Based Waiver Programs

- The short-term, time-limited, medical nature of P/RSPCE and its linkage to primary care are important in understanding the relationship between these two Medicaid services.

- The P/RSPCE provider must fully understand how the waiver program operates, the waiver and state plan services available, and scope of the Community Long Term Care case manager (CM)/Department of Disabilities and Special Needs service coordinator (SC). This is critical to avoid any unnecessary duplication or overlap services.

- It is important that the P/RSPCE provider and the assigned waiver recipient's CM/SC communicate exactly what service(s) will be provided as well as the exact expected outcome of the intervention(s) being provided. This communication is necessary to ensure the recipient's waiver plan of care/service is documented appropriately by the CM/SC.

- The P/RSPCE provider will document all telephone or personal contacts with the CM/SC in the client's case record.

- P/RSPCE services provided to waiver recipients must be within the 30 units/month limit established by DHHS. These services must be efficient, well managed, and must not duplicate any waiver or state plan services.

- DHHS will monitor the amount of P/RSPCE provided to waiver recipients through Medicaid expenditure reports.

- Only nutrition services can be routinely provided to waiver recipients under P/RSPCE.

- Any other P/RSPCE provided to home and community-based waiver recipients must meet one of the criteria below:

    1. Interventions related to a client's complicated medical condition to improve his/her response to treatment or care. There must be clear documentation that the P/RSPCE provider has communicated with the primary care physician and CM/SC concerning the nature of the service(s) to be provided;

    2. Interventions for clients with complicated medical conditions in need of medication management, compliance with a medication regimen, or assistance in procuring medications. Routine situations should be handled through Medicaid state plan (including Medicaid home health services) or waiver services. P/RSPCE involvement should only be for crisis-type situations that are short-term, time-limited, medical, and carefully coordinated with the CM/SC; or

3. Interventions for clients with complex medical conditions to assure understanding of how multiple medical treatments relate with the effectiveness of the care plan in order to maximize the level of independence and functioning. This may involve attending a discharge or case coordination meeting (with the CM/SC) where a deinstitutionalization is imminent. This cannot duplicate the functions of the CM/SC.

- Waiver recipient's meeting any of the above criteria may be referred for P/RSPCE by their CM/SC.

- These procedures will be communicated to the responsible P/RSPCE staff, CLTC staff, and DDSN staff.

Attachment: Contracted Provider List

Effective Date: September 1, 1998

For Your Information:

MR/RD Waiver and Hospice Services

When an MR/RD Waiver recipient elects to also receive State Plan Hospice Services, the Hospice provider becomes the "Authorizer" of all services. That means that you must obtain authorization from the Hospice provider before board provided waiver services, such as Residential Habilitation, can be provided. Once it is determined what services the consumer will receive, the Hospice authorization number should be obtained (e.g. HSP028). This Authorization number must be communicated to your District MR/RD Waiver Coordinator along with the consumer's name, social security number, county in which the consumer resides, date the consumer entered Hospice, Medicaid Number, the Service Coordinator/ Early Interventionist's name and the services that the consumer will receive. The District MR/RD Waiver Coordinator will be responsible for reporting this information to SCDDSN Central Office—SURB for billing purposes.

You cannot authorize any services for MR/RD Waiver recipients who elect to receive Hospice Services funded by Medicaid unless you receive a prior authorization number from the Hospice provider.

The following MR/RD Waiver services in the left column may be routinely authorized by DDSN if appropriate. Those services in the right column may not be authorized for clients also receiving the Hospice benefit:

May be routinely authorized if appropriate	**May not be authorized**
Residential Habilitation	Nursing Services
Prescribed Drugs	Adult Day Health Care
Adult Dental Services	Adult Day Health Care –Nursing
Adult Vision	Audiology Services
Specialized Medical Equipment, Supplies and Assistive Technology *Note: this service will be limited to those items already identified on the plan of service. These services will not be authorized for newly requested items for waiver clients entering hospice.	Attendant Care
	Respite Care
	Behavior Support Services
	Speech-Language Pathology
	Physical Therapy
	Occupational Therapy
	Adult Companion Services
	Psychological Services
	Personal Care I and II
	Environmental Modifications
	Private Vehicle Modifications
	Day Habilitation
	Prevocational Habilitation
	Supported Employment

For Your Information

Subject: Out of State Travel

MR/RD Waiver recipients may travel out of state and retain a waiver slot under the following conditions:

- the trip is planned and will not exceed 90 consecutive days;
- the recipient continues to receive a waiver service consistent with SCDDSN policy;
- the waiver service received is provided by a South Carolina Medicaid provider;
- South Carolina Medicaid eligibility is maintained.

During travel, waiver services will be limited to the frequency of service currently approved in the recipient's plan. Services must be monitored according to SCDDSN policy.

The parameters of this policy are established by SCDHHS for all HCB Waiver recipients.

For Your Information

Subject: Income Trust

If a potential recipient is deemed "not eligible" for Medicaid due to excessive income, he/she may become eligible after an "Income Trust" is established. The potential recipient must meet all other Medicaid eligibility criteria.

Under this option, the potential recipient establishes a trust account into which all of his/her income is deposited. Each month, after appropriate deductions for living expenses and other fees, Medicaid bills the trust for any Medicaid services provided.

Specific and detailed information about Income Trusts is available from the South Carolina Department of Health and Human Services (SCDHHS/Eligibility).

Trusts must be set up by an attorney or trust professional and must be set up according to the specific guidelines set by SCDHHS/Eligibility.

PURGING A MR/RD WAIVER FILE

- Clearly denote on the working file that there is a back-up file by placing a **Back-Up File Available** sticker on the front of the file or follow your agency's policy for denoting a Back-Up File Available.

- All material (except Waiver information) should be purged by calendar year and put in a file that is set up like the working file and labeled as a back-up file.

- The original Social History and all Social Updates remain in the file.

- All Service Agreements will be maintained in the working file.

- Client Rights and Review of Record Form remains in the working file.

- Voter Registration Information remains in the working file.

- Retain previous and current Plan in the working file.

- Current medical exam and medical records should be in the file.

- All psychological evaluations remain in the working file.

- Current and previous IEP/IPP, if applicable, should be retained in the working file.

- The E&P letter regarding eligibility should remain in the working file.

- Contact notes will be purged according to calendar year. The current year should remain along with two previous years to coincide with the budgets.

- For Waiver files, the Freedom of Choice, Waiver Enrollment letter, VR Letter/Request for Determination of Availability of Service MR/RD Form VR, Notice of Intent MR/RD Form 5, and all Level of Care determinations remain in the working file.

- Waiver budget information should be purged according to fiscal year (i.e.7/1/00-6/30/01) along with pertinent documents: referrals, monthly utilization forms, requisitions/invoices, and progress notes regarding Waiver provided services. The current contract period should remain along with the previous contract period. This should coincide with your contact notes (i.e. if the current contract period is 7/1/00-6/30/01 the you must retain this information in the working file along with 7/1/99-6/30/00 budget information and supporting documents which coincide with service notes from 1999-2001--the service notes would be purged back to 1/1/99).

South Carolina Department of Health and Human Services
Service Contacts
P.O. Box 8206
Columbia, SC 29202-8206

If you have concerns or questions regarding any waiver service, you must contact your Regional MR/RD Waiver Coordinator. If when working with a provider of MR/RD Waiver services there are problems with direct billing to SCDHHS, etc. then refer them to their designated SCDHHS worker listed below. You should NEVER make contact directly with these workers unless you have specific instructions from SCDDSN Central Office.

Adult Day Health Care	Tony Matthews 898-2590
Adult Dental Services	Pat Cooper 898-2563
Adult Vision Services	Nathan Zavala 898-2569
Audiology Services	Tara Satterfield 898-2583
Behavior Support Services	Jon Tapley 898-2702
Environmental Modifications	Tony Matthews 898-2590
Nursing Services	Tony Matthews 898-2590
Occupational Therapy Services	Deborah McCoy (school-based) 898-2655 Tara Satterfield (Private OT) 898-2583
Personal Care Services (I and II)	Tony Matthews 898-2590
Physical Therapy Services	Deborah McCoy (school-based) 898-2655 Tara Satterfield (Private PT) 898-2583
Prescribed Drugs	Jan Scharstein 898-2881
Private Vehicle Modifications	Zanipha Mohamed 898-2879
Psychological Services	Jon Tapley 898-2702
Speech Language Pathology	Tara Satterfield 898-2583

Specialized Medical Equipment, Supplies, and Assistive Technology

<u>Michelle Abney (898-4577)</u>

Cherokee	Laurens
Chester	Oconee
Colleton	Pickens
Fairfield	Union
Florence	York
Lancaster	

<u>Evelyn Johnson (898-2880)</u>

Aiken	Georgetown
Calhoun	Kershaw
Chesterfield	Richland
Clarendon	Saluda
Edgefield	Sumter
Dorchester	Williamsburg

Zanipha Mohamed (898-2879)

Anderson	Lee
Abbeville	McCormick
Charleston	Marlboro
Darlington	Marion
Dillon	Spartanburg
Greenwood	

Jane Wood (898-2873)

Allendale	Hampton
Bamberg	Horry
Barnwell	Jasper
Beaufort	Lexington
Berkeley	Newberry
Greenville	Orangeburg